Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

In the Matter of	)	
	)	
Promoting Telehealth for	)	WC Docket No. 18-213
Low-Income Consumers	)	

COMMENTS OF MYNEXUS

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August 29, 2019

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On behalf of the thousands of clinicians with whom we partner and the hundreds of thousands of patients they serve across the United States, myNEXUS is grateful for the opportunity to respond to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking ("NPRM") in the above-captioned proceeding.

I. INTRODUCTION AND SUMMARY

As the Commission already knows so well, many of America's rural and disadvantaged communities are suffering a severe healthcare access crisis. Medical needs that could be prevented are instead manifesting themselves, and treatment that could proactively address them and prevent costly interventions is too often unavailable. Indeed, medical conditions that could, and should, be proactively managed to prevent acute events, are instead exacerbating into increasingly poor health outcomes leading to ever-increasing health care costs in the U.S, without opportunities for preventative treatment and ongoing chronic condition care management. For that reason, the proposed Connected Care Pilot Program ("Pilot") has resonated across the healthcare community as an important opportunity to address these critical problems.

myNEXUS is proud to be participating in this conversation. As a leading provider of Advanced Care Management Technology ("ACMT") solutions, we know technology can serve

as the bridge between patients and the skilled providers they need. That is why our mission is to transform healthcare delivery and promote medical progress by leveraging advanced technology so it can extend the reach and impact of clinical expertise.

To accomplish this mission, our skilled team utilizes advanced technology and care management protocols to help patients avoid costly institutional stays and remain healthy and independent in their communities. Today, myNEXUS' platform is used in urban, suburban, and rural communities in 18 states where it is expanding access to care, proactively addressing medical needs, and achieving substantial savings through the avoidance of costly emergency room visits and hospital stays.

II. THE PRESSING NEED FOR AND BENEFITS OF TELEHEALTH WARRANT IMPLEMENTATION OF THE CONNECTED CARE PILOT PROGRAM

Over the course of the past year, myNEXUS has applied its experience to an analysis of the Connected Care Pilot Program, and the comments we offer below are informed by our findings. In brief, we project the proposed Pilot will directly address a demonstrated need in numerous unserved communities. As evidenced by the widespread closure of rural hospitals and the ravages of the ongoing opioid epidemic, communities throughout Rural America and other underserved areas are suffering. Absent bold action, the crisis they are facing today is likely to worsen and claim even more victims.

Just as important, we believe the Pilot would have a significant impact across a broad range of metrics that are central to the effective and efficient operation of America's healthcare programs. These metrics include but are not limited to improved health status, lower admission rates to hospitals and other institutional settings, enhanced access to home and community-based services, and materially reduced federal and state cost.

Finally, we believe the Pilot is well suited to a rigorous analytics framework that can demonstrate the clinical, fiscal, and human value of connected care. Not only is such a factor important for any taxpayer-funded program but it may be of particular benefit here as we believe the Pilot can satisfy a significant need by serving as a replicable model for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Veterans Health Administration (VHA), and the Indian Health Service (IHS).

For these reasons, we respectfully submit that the Connected Care Pilot Program is of real importance and is worthy of implementation.

That said, we would like to underscore a fundamental viewpoint on the role we believe the Connected Care Pilot Program can and should optimally play. We do not envision the Pilot as a payor of healthcare services, since most impacted patients are already covered by Medicare, Medicaid, CHIP, the VA, IHS, or other health programs. Nor do we believe its resources should be used to fund the installation of institutional healthcare infrastructure, since care is rapidly evolving towards the home and community-based model in an ever-expanding scope of services. Instead, we recommend the Pilot be utilized to help build the technological *bridge* – via such means as remote telehealth monitoring and care management – that will enable such services to reach patients in need who reside in rural and other unserved areas.

Across America, academic medical centers operate a hub and spoke model to triage rural patients in community hospitals and move them to urban centers for needed care. As community hospitals fail, however, the hub and spoke model is also failing. Today, this scenario is playing out in rural and other struggling communities across the U.S., where hospital closures and an inadequate supply of physicians are producing a very costly yet avoidable crisis.

We are convinced the Connected Care Pilot Program can make great strides in addressing this problem in two important ways: by delivering broadband-enabled telehealth services directly to patients in their homes and communities (i.e., outside of brick-and-mortar health care facilities); and by improving health outcomes and reducing costs via such means as readmission avoidance and by closely tracking performance to gauge the Pilot's efficacy.

We reached this conclusion by examining two communities that illustrate the crisis endemic to many across the nation: Farner, Tennessee and Valentine, Texas.

We began with Tennessee due to a variety of documented challenges its residents face. More than eighty percent of its counties are rural, one-fifth of them are among the poorest and most unemployed in the U.S., and the state has been shaken by numerous hospital closures. Within Farner and its county (Polk), the population is disproportionately poor, elderly, disabled, unemployed, and uninsured. Within thirty miles of Farner there is just one physician – and not a single hospital. Due to this lack of healthcare access, residents are suffering. Adults there face higher premature death rates, experience more preventable hospital stays (in distant facilities), and exhibit troubling statistics in a number of vital areas, including low birthweight, obesity, and diabetes.

In many respects, Texas is faring little better. Statewide, twenty-two counties have only one physician present, and another twenty-seven have none. Hospital closures have occurred across the state at the highest rate in the U.S., and the rate of uninsurance is the highest in the nation. In west Texas, where the small town of Valentine is located, the situation is particularly acute. Residents of Valentine and its county (Jeff Davis) are more likely to be poor, unemployed, elderly, and unable to access needed care than Texans in more populous

communities. Data indicate Valentine residents are more likely to suffer chronic conditions, low birthweight, and preventable hospitalization than other Texas, as well.

Unfortunately, Farner and Valentine are not the only communities facing such serious problems; instead, their plight can be found wherever hospital closures and caregiver shortages have stretched access to the breaking point. The Commission's proposed Pilot is therefore being considered at a critically important time. By connecting individuals in unserved communities with remote patient monitoring, telehealth, and care management services, the Pilot can bridge the gaps that today drive suboptimal health outcomes and high, avoidable cost. We therefore hope our comments on the following questions will be of value to the Commission as it decides on the future of the Connected Care Pilot Program.

III. COMMENTS ON QUESTIONED POSED BY THE COMMISSION

In the following pages, we wish to address questions posed by the Commission that fall within our experience and areas of expertise.

Supported Services

To what extent are health care providers already funding patient broadband connections for connected care services and what are the costs associated with funding those connections, and to what degree would providing universal service funding to offset these costs enable health care providers to extend service to additional patients or treat additional health conditions?

- In our experience, the principal cost-related obstacle is not the broadband connection but the delivery of patient-centric remote monitoring and care management services

over broadband. If the Pilot were to solely fund the connection without the care management component, patients would indeed gain reliable access to broadband-enabled services. However, the absence of remote monitoring or care management would mean that patients' access to needed healthcare services and, thus, their health status would be little changed. As a result, we urge consideration of broadband funding not for its own sake but to serve as the technological bridge for the delivery of remote monitoring and care management to patients in need who reside in rural and other unserved areas.

Should the term "connected care" be established as a defined subset of telehealth and focus on delivering remote medical, diagnostic, and treatment-related services directly to patients outside of traditional brick and mortar facilities?

- We encourage the Commission to proceed with its proposed definition and to ensure it includes both a range of professionals (including physicians, nurses, behavioral health specialists, pharmacists, and social workers) and a range of services (including medical, diagnostic, behavioral, treatment-related, and supportive care services).

Should we place any additional qualifiers on this definition to ensure that the Pilot program is focused on medical services delivered directly to patients outside of traditional medical facilities through broadband-enabled technologies?

- We encourage the Commission to incorporate the additional qualifier of "home and community-based services" in its definition for connected care for the following reasons: this qualifier will enable the Pilot program to better conform to the realities

within the communities most in need of its assistance, since institutional settings are few or entirely absent within them; and, it will also enable the Pilot program to more closely sync with the healthcare programs that are most likely to serve as the payor of services delivered through the Pilot, such as Medicare, Medicaid, and the Veterans Health Administration, all of which are rapidly moving toward expanded use of home and community-based services.

Are there any barriers to receiving connected care services for low-income patients and veterans, and, if so, what are those barriers?

- In our experience, it is insufficient and can be counterproductive to deliver remote monitoring or care management services without training for the patient and family, skilled oversight, and continuous coordination of services. As a result, we urge the Commission not to consider the Pilot program as complete if it solely underwrites the broadband connection to these services. Instead, we recommend a holistic view consistent with the definition discussed above: a comprehensive platform in which broadband connectivity is made available so that remote monitoring and care management services can be provided, spanning a broad range of healthcare professionals and vital interventional and health maintenance services.

Network Equipment

Should the Pilot program dedicate funds to support health care provider administrative and outreach costs associated with participating in the Pilot program (such as personnel costs, and program management costs)?

- We wish to discourage the use of Pilot program funds for such costs, both because the Commission is correct that providers "will participate even without the program funding administrative expenses" and because using funds for such purposes will reduce the resources available to expanding access to connected care and the remote monitoring and care management it will make possible.

End-User Devices, Medical Equipment, Mobile Applications, and Health Care Provider Administrative Expenses

Should the Pilot program fund end-user equipment, medical devices, or mobile applications for connected care?

- We concur with the Commission and recommend that funding not be diverted to use for such purposes. We believe providers and entities who are committed to the Pilot's success will self-fund or obtain other resources for end-user devices, medical devices, and mobile applications. As a result, we instead urge prioritized use of Pilot funds for the connectivity, remote monitoring, and care management that can make the most difference in unserved communities.

Budget

Should each selected project's funding commitment be divided evenly across the Pilot program duration? For example, if a selected project receives a $9 million funding commitment and the funding period is three years, should the project receive $3 million for each year?

- Due to the many variables involved in Pilot participation and the importance of operational stability, we recommend dividing the budget and awards evenly across the three years of operation.

Number of Pilot Projects and Amount of Funding Per Project

Should we establish a discount level of 85% that requires participants to contribute the remaining portion of the costs, including being administratively simple, predictable, and equitable, and incentivizing participants to choose the most cost-effective services and equipment and refrain from purchasing a higher level of service or equipment than needed?

- Yes, we recommend the Commission adopt this approach for the Pilot.

Should we set a fixed number of projects (i.e., up to 20 projects with awards of $5 million per project) or not expressly limit the number of funded Pilot projects and permit flexible and varied funding for each selected Pilot project?

- We recommend the Commission adopt the latter approach. We concur with the perspectives articulated in the NPRM that "setting a fixed number of funded projects would not serve the goals of the Pilot program because it would artificially limit the number of funded projects before any proposals are even submitted." We also agree

that not setting a fixed number of projects will enable the Commission "to better focus on selecting quality projects that can provide meaningful data".

Duration

Should the Pilot program have a two- or three-year funding duration and six-month ramp-up and wind-down periods?

- We recommend the Pilot program have a three-year duration with separate ramp-up and wind-down periods not to exceed six months each.

When should the ramp-up period begin, should funding disbursements begin during the ramp-up period (and, if so, how should funding be split between the ramp-up period and the Pilot project term), and should we propose setting a fixed end date for the Pilot program?

- We recommend the ramp-up period begin not later than July 1, 2020, that up to one-half of the first full year's funding disbursement be made available during the ramp-up period, and that the program have an end date of December 31, 2022, followed by the wind-down period, unless a participant demonstrates to the Commission that circumstances warrant an extension.

Eligible Health Care Providers

Should we limit health care provider participation in the Pilot program to non-profit or public health care providers within section 254(h)(7)(B)?

- In order to best position the Pilot program for success, we strongly urge the Commission not to impose this limitation, for the following reasons: First, the evolving healthcare marketplace includes a growing number of innovative, sophisticated providers and entities who do not fit within this narrow restriction. Second, many of the providers who do, such as skilled nursing facilities, are often not present in unserved communities and do not deliver the most clinically- and cost-effective care available. Third, this limitation is narrower than any being utilized by such programs as Medicare, Medicaid, and the VHA, thereby undermining the Pilot's ability to sync up with and leverage the administrative and operational efficiencies of those programs. And fourth, by prioritizing some level of administrative alignment over the most advanced, patient-centric care delivery available, this limitation would only serve to deny unserved communities the benefit of being able to access the full range of providers and entities who may wish to participate in the Pilot.

What criteria should we require and steps should we take to ensure that participating health care providers have significant experience with providing long-term patient care, in order to guard against waste, fraud, and abuse in the Pilot program?

- We recommend the Commission adopt criteria and safeguards consistent with Health and Human Services (HHS) policies and Inspector General recommendations, such as: an established track record of service of not fewer than three years, delivery of patient care and/or coordination services to patients that have exceeded six months, clean criminal background checks of the officers and lead participants of each

provider group or other entity, proof of defined financial qualifications, and the absence of any criminal charge or settlement relating to the provider or entity.

What criteria could demonstrate connected care companies' and health care providers' experience with delivering long-term care for patients?

- Demonstrated experience serving patients for more than six months, delivery and/or coordination of home and community-based services, and ongoing direct, telephonic, and/or electronic interaction with patients would all demonstrate this capability.

To ensure projects meet the goals of the Pilot program, should we require participating providers to have experience integrating remote monitoring and telehealth services, limit eligibility to those providers that are federally designated as Telehealth Resource Centers or as Telehealth Centers of Excellence, or otherwise require them to demonstrate their experience providing telehealth services?

- Participating providers should not be limited solely to those that are federally designated as Telehealth Resource Centers or as Telehealth Centers of Excellence, but they should be required to demonstrate this experience, either due to their own capabilities or their operational affiliation with entities that specialize in remote monitoring, care management, and other telehealth services.

Application Process

Should we require interested health care providers to submit an application describing the proposed Pilot project and providing information that will facilitate the selection of high-quality

projects or should we require applicants to obtain all necessary eligible telecommunications carrier (ETC) designations prior to selection?

- In order to attract interest from the full breadth of clinical and connected care innovators that can best assure the Pilot of success, we recommend the Commission adopt the former approach and then assist selected participants with the ETC designation process.

If we issue an order establishing the proposed Pilot program, would requiring that applications be submitted within 120 days from the release of such an order give health care providers sufficient time to develop and submit a meaningful application for the Pilot program?

- Yes.

Evaluation of Proposals and Selection of Projects

In addition to considering whether each project would serve the Pilot program goals, whether the applicant is able to successfully implement, operate, and evaluate the outcomes of the project, and the cost of the proposed project compared to the total Pilot program budget, what other objective factors should be used to evaluate the proposals?

- We recommend inclusion of factors relating to an applicant's demonstrated experience in remote monitoring, care management, and other telehealth services, as well as the applicant's demonstrated ability to achieve net reduction in healthcare

costs due to such capabilities (benchmarked against similar communities not involved in the pilot).

Should we award points to proposed projects that would serve geographic areas or populations where there are well-documented health care disparities (such as Tribal lands, rural areas, or veteran populations) and/or that treat certain health crises or chronic conditions that significantly impact many Americans and are documented to benefit from connected care, such as opioid dependency, diabetes, heart disease, mental health conditions, and high-risk pregnancy?

- Yes, we believe that such areas of emphasis should be included and accrue award points. In addition to those noted above, we recommend inclusion of criteria relating to a proposed project's service to low-income individuals, homebound individuals, and those residing in an area in which no hospital remains present within a specified geographic area.

Selecting Service Providers

Should we require participating health care providers, and not the participating patients, select the service provider that will deliver the connected care services and equipment funded through the Pilot program?

- Yes. In our experience, providers – not patients – are in the best position to know the service and performance requirements necessary to provide connected care services and therefore are best able to select qualified, experienced service providers. We

further agree with the perspective articulated in the NPRM that this approach can generate cost efficiencies and optimal service arrangements.

Requesting Funding

Should we require selected Pilot program participants to submit funding requests within six months of the date of their respective selection notices for the Pilot program and then for each year of the Pilot thereafter?

- We believe the six month timeframe will give participants sufficient time to select their vendor and submit a funding request, but we do not think participants should be required to submit a new funding request for each year of the Pilot program.

Should we require selected projects to certify that the provided funding will only be used for the eligible Pilot program purposes, that the supported services and equipment will only be used for purposes reasonably related to services or instruction that are legally authorized, and who will be legally and financially responsible for the activities supported through the Pilot?

- Absolutely yes.

Disbursements

Should the project's compliance with the Pilot's data reporting requirements be a basis for continued issuance of disbursements?

- Yes – the Pilot will not be a success if it is unable to demonstrate the clinical, fiscal, and human efficacy of connected care, so no funds should continue to be disbursed to any participant who fails to comply with the Pilot's data reporting requirements.

Ensuring Effective and Responsible Use of Funds

Should we focus on the following primary program goals: (1) improving health outcomes through connected care; (2) reducing health care costs for patients, facilities, and the health care system; (3) supporting the trend towards connected care everywhere; and (4) determining how Universal Service Fund (USF) resources can positively impact existing telehealth initiatives?

- Yes. These metrics are central to the design and success of the Pilot program and they are readily quantifiable and demonstrable, so we recommend their inclusion as primary program goals.

Metrics

What specific metrics and methodologies should we utilize to measure progress towards our proposed program goals?

- To ensure the Pilot's findings are firm and not qualitative, we recommend the use of metrics and methodologies that are well-established, fully quantifiable, and relied upon by such programs as Medicare, Medicaid, and VHA. Examples include: reductions in emergency room or urgent care visits; decreases in institutional (hospital, skilled nursing facility, and other setting) admissions or re-admissions;

condition-specific outcomes such as reductions in premature births, premature adult deaths, and acute incidents among sufferers of a chronic illness; patient satisfaction; medication adherence; and total cost of care.

Should we require Pilot program proposals to identify non-USF sources of funding or support and to report how USF support for connected care enables participants to leverage existing resources or other telehealth services?

- Yes. The Pilot program will suffer from a duplication of efforts and resources if it provides rather than enables participants to leverage other resources, such as payment for health care services. For example, a participant who uses Pilot funds to defray the cost of connectivity and brings remote monitoring, care management, and other telehealth services to residents of an unserved community will be able to obtain payment for the resulting healthcare services from the payor(s) applicable to the individuals served, such as Medicare, Medicaid, VHA, IHS, or CHIP. This is a powerful opportunity and should be fully identified and reported.

Data Gathering and Reporting

Should participants be required to submit regular reports with anonymized, aggregated data that will enable the Commission to monitor the progress of each project and ultimately evaluate the Pilot program, as a condition of receiving the proposed support?

- Yes. As previously stated, the findings of this Pilot are critical both to its mission and the subsequent opportunity to replicate its success. As a result, we recommend clear,

detailed requirements for data and analytics submission, which we recommend be undertaken on a quarterly basis.

Clinical Trials

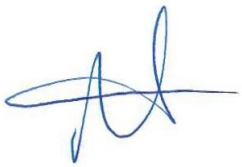
What is the appropriate method for measuring the health effects of the connected care Pilot projects: should all projects be required to conduct randomized controlled trials to determine the effect of the treatments on patients' health or are there alternative, less costly methods that are statistically sound and can accurately measure the effect of the treatment?

- We recommend that participants be required to independently or, under contract with an affiliated entity, jointly conduct and submit analyses of the impact of their telehealth services on established health metrics in the region(s) they serve. For accuracy and completeness, we also recommend that such analyses include the data fields and patient survey questions articulated in the NPRM.

III. CONCLUSION

The Connected Care Pilot Program represents an important and exciting step forward in the delivery of clinically-advanced, cost-effective telehealth services to some of America's most disadvantaged and vulnerable communities. myNEXUS is grateful for the opportunity to present our perspectives on this NPRM to the Commission, and we look forward to continuing this dialogue as work on the Pilot proceeds. If you have any questions or need further information, please do not hesitate to contact me or Scott Vasey, myNEXUS' Chief Strategy Officer, at svasey@mynexuscare.com.

Respectfully submitted,



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